Complete Summary

TITLE

Postoperative wound dehiscence (area-level): rate of reclosure of abdominal wall per 100,000 population.

SOURCE(S)

AHRQ quality indicators. Guide to patient safety indicators [version 3]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 72 p.(AHRQ Pub; no. 03-R203).

Measure Domain

PRIMARY MEASURE DOMAIN

Population Health

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

SECONDARY MEASURE DOMAIN

Does not apply to this measure

Brief Abstract

DESCRIPTION

This measure is used to assess the number of cases of reclosure of postoperative disruption of abdominal wall per 100,000 population.

RATIONALE

Hospitals in the United States provide the setting for some of life's most pivotal events - the birth of a child, major surgery, treatment for otherwise fatal illnesses. These hospitals house the most sophisticated medical technology in the world and provide state-of-the-art diagnostic and therapeutic services. But access to these services comes with certain costs. About 30% of personal health care expenditures in the United States go towards hospital care, and the rate of growth in spending for hospital services has only recently leveled out after several years of increases following a half a decade of declining growth. Simultaneously, concerns about the quality of health care services have reached a crescendo with

the Institute of Medicine's series of reports describing the problem of medical errors and the need for a complete restructuring of the health care system to improve the quality of care. Policymakers, employers, and consumers have made the quality of care in U.S. hospitals a top priority and have voiced the need to assess, monitor, track, and improve the quality of inpatient care.

Widespread consensus exists that health care organizations can reduce patient injuries by improving the environment for safety from implementing technical changes, such as electronic medical record systems, to improving staff awareness of patient safety risks. Clinical process interventions also have strong evidence for reducing the risk of adverse events related to a patient's exposure to hospital care. Patient Safety Indicators (PSIs), which are based on computerized hospital discharge abstracts from the AHRQ's Healthcare Cost and Utilization Project (HCUP), can be used to better prioritize and evaluate local and national initiatives. Analyses of these and similar inexpensive, readily available administrative data sets may provide a screen for potential medical errors and a method for monitoring trends over time.

The Postoperative Wound Dehiscence indicator is intended to flag cases of wound dehiscence in patients who have undergone abdominal and pelvic surgery. This indicator is defined both on a provider level (by including cases based on secondary diagnosis associated with the same hospitalization) and on an area level (by including all cases of wound dehiscence) (see the related National Quality Measures Clearinghouse [NQMC] summary of the Agency for Healthcare Research and Quality [AHRQ] indicator Postoperative wound dehiscence (provider-level): rate of reclosure per 1,000 cases of abdominopelvic surgery).

PRIMARY CLINICAL COMPONENT

Postoperative wound dehiscence

DENOMINATOR DESCRIPTION

Population of county or Metro Area associated with Federal Information Processing Standards (FIPS) code of patient's residence or hospital location

NUMERATOR DESCRIPTION

Discharges, age 18 years or older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code for reclosure of postoperative disruption of abdominal wall (5461) in any procedure field

Exclude patients with immunocompromised states and Major Diagnostic Category (MDC) 14 (pregnancy, childbirth, and puerperium).

Evidence Supporting the Measure

EVIDENCE SUPPORTING THE VALUE OF MONITORING THE ASPECT OF POPULATION HEALTH

- A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences
- One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Monitoring health state(s)
Variation in health state(s)

EVIDENCE SUPPORTING NEED FOR THE MEASURE

AHRQ quality indicators. Guide to patient safety indicators [version 3]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 72 p.(AHRQ Pub; no. 03-R203).

State of Use of the Measure

STATE OF USE

Current routine use

CURRENT USE

Federal health policymaking
Monitoring health state(s)
National reporting
State health policymaking

Application of Measure in its Current Use

CARE SETTING

Unspecified

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Physicians
Public Health Professionals

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Counties or Cities

TARGET POPULATION AGE

Unspecified

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Unspecified

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

Unspecified

ASSOCIATION WITH VULNERABLE POPULATIONS

Unspecified

BURDEN OF ILLNESS

Unspecified

UTILIZATION

Unspecified

COSTS

Unspecified

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Getting Better

IOM DOMAIN

Safety

Data Collection for the Measure

CASE FINDING

Both users and nonusers of care

DESCRIPTION OF CASE FINDING

Population of county or Metro Area associated with Federal Information Processing Standards (FIPS) code of patient's residence or hospital location

DENOMINATOR SAMPLING FRAME

Geographically defined

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
Population of county or Metro Area associated with Federal Information Processing Standards (FIPS) code of patient's residence or hospital location

Exclusions
Unspecified

RELATIONSHIP OF DENOMINATOR TO NUMERATOR

All cases in the denominator are not equally eligible to appear in the numerator

DENOMINATOR (INDEX) EVENT

Patient Characteristic

DENOMINATOR TIME WINDOW

Time window is a single point in time

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
Discharges, age 18 years or older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code for reclosure of postoperative disruption of abdominal wall (5461) in any procedure field

Exclusions
Exclude patients with immunocompromised states and Major Diagnostic Category (MDC) 14 (pregnancy, childbirth, and puerperium).

MEASURE RESULTS UNDER CONTROL OF HEALTH CARE PROFESSIONALS, ORGANIZATIONS AND/OR POLICYMAKERS

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

NUMERATOR TIME WINDOW

Unspecified

DATA SOURCE

Administrative data
National public health data

LEVEL OF DETERMINATION OF QUALITY

Does not apply to this measure

TYPE OF HEALTH STATE

Adverse Health State

PRE-EXISTING INSTRUMENT USED

Unspecified

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

A lower score is desirable

ALLOWANCE FOR PATIENT FACTORS

Unspecified

STANDARD OF COMPARISON

External comparison at a point in time
External comparison of time trends
Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

The Patient Safety Indicators (PSIs) were evaluated by the project team using empirical analyses to explore the frequency and variation of the indicators, the potential bias, based on limited risk adjustment, and the relationship between indicators. The data sources used in the original empirical analyses were the 1997 Florida State Inpatient Database (SID) for initial testing and development and the 1997 Healthcare Cost and Utilization Project (HCUP) State Inpatient Database for 19 States for the final empirical analyses.

All potential indicators were examined empirically by developing and conducting statistical tests for precision, bias, and relatedness of indicators. Three different estimates of hospital performance were calculated for each indicator:

1. The raw indicator rate was calculated using the number of adverse events in the numerator divided by the number of discharges in the population at risk by hospital.
2. The raw indicator was adjusted to account for differences among hospitals in age, gender, modified Diagnosis-Related Group (DRG), and comorbidities.
3. Multivariate signal extraction methods were applied to adjust for reliability by estimating the amount of "noise" (i.e., variation due to random error) relative to the amount of "signal" (i.e., systematic variation in hospital performance or reliability) for each indicator.

The project team constructed a set of statistical tests to examine the precision, bias, and relatedness of indicators for all accepted Provider-level Indicators, and precision and bias for all accepted Area-level Indicators. It should be noted that rates based on fewer than 30 cases in the numerator or the denominator are not reported.

The project team conducted a structured review of each indicator to evaluate the face validity (from a clinical perspective) of the indicators. The methodology for the structured review was adapted from the RAND/UCLA Appropriateness Method and consisted of an initial independent assessment of each indicator by clinician panelists using an initial questionnaire, a conference call among all panelists, followed by a final independent assessment by panelists using the same questionnaire. The review sought to establish consensual validity, which "extends face validity from one expert to a panel of experts who examine and rate the appropriateness of each item..." The panel process served to refine definitions of some indicators, add new measures, and dismiss indicators with major concerns from further consideration.

Refer to the original measure documentation for additional details.

EVIDENCE FOR RELIABILITY/VALIDITY TESTING

AHRQ quality indicators. Guide to patient safety indicators [version 3]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 72 p.(AHRQ Pub; no. 03-R203).

Identifying Information

ORIGINAL TITLE

Postoperative wound dehiscence (area level definition) (PSI 24).

MEASURE COLLECTION

Agency for Healthcare Research and Quality (AHRQ) Quality Indicators

MEASURE SET NAME

Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators

DEVELOPER

Agency for Healthcare Research and Quality

INCLUDED IN

National Healthcare Quality Report (NHQR)

ADAPTATION

An indicator on this topic (9983) was originally proposed by Hannan and colleagues (1989) to target "cases that would have a higher percentage of quality of care problems than cases without the criterion, as judged by medical record review." The same code was included within a broader indicator ("adverse events and iatrogenic complications") in the Agency for Healthcare Research and Quality's (AHRQ's) original Healthcare Cost and Utilization Project (HCUP) Quality Indicators (Elixhauser et al., 1998). Iezzoni and colleagues (1994) identified an associated procedure code for reclosure of an abdominal wall dehiscence (5461), and included both codes in the Complications Screening Program. Miller and colleagues (2001) suggested the use of both codes (as "wound disruption") in the original "AHRQ Patient Safety Indicator (PSI) Algorithms and Groupings."

RELEASE DATE

2003 Mar

REVISION DATE

2006 Feb

MEASURE STATUS

Please note: This measure has been updated. The National Quality Measures Clearinghouse is working to update this summary.

SOURCE(S)

AHRQ quality indicators. Guide to patient safety indicators [version 3]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 72 p.(AHRQ Pub; no. 03-R203).

MEASURE AVAILABILITY

The individual measure, "Postoperative Wound Dehiscence (Area Level Definition) (PSI 24)," is published in "AHRQ Quality Indicators. Guide to Patient Safety Indicators." An update of this document is available from the Quality Indicators page at the Agency for Healthcare Research and Quality (AHRQ) Web site.

For more information, please contact the QI Support Team at support@qualityindicators.ahrq.gov.

COMPANION DOCUMENTS

The following are available:

- AHRQ quality indicators. Patient safety indicators: technical specifications [version 3.0]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 102 p. An update of this document is available in Portable Document Format (PDF) from the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators Web site.
- AHRQ Quality Indicators. Patient safety indicators: software documentation [version 3] - SAS. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 42 p. (AHRQ Pub; no. 03-R204). An update of this document is available in Portable Document Format (PDF) from the AHRQ Quailty Indicators Web site.
- AHRQ Quality Indicators. Patient safety indicators: software documentation [version 3] - SPSS. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 38 p. (AHRQ Pub; no. 03-R205). This document is available in PDF from the AHRQ Quailty Indicators Web site.
- AHRQ quality indicators. Software documentation: Windows [version 3.0]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2006 Feb 20. 72 p. This document is available in PDF from the AHRQ Quality Indicators Web site.
- Remus D, Fraser I. Guidance for using the AHRQ quality indicators for hospital-level public reporting or payment. Rockville (MD): Agency for Healthcare Research and Quality; 2004 Aug. 24 p. This document is available in PDF from the AHRQ Quality Indicators Web site.
- AHRQ summary statement on comparative hospital public reporting. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005 Dec. 1 p. This document is available in PDF from the AHRQ Quality Indicators Web site.
- Guidance for using the AHRQ quality indicators for public reporting or payment - appendix A: current uses of AHRQ quality indicators and considerations for hospital-level reporting. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005 Dec. A1-13 p. This document is available in PDF from the AHRQ Quality Indicators Web site.
- Guidance for using the AHRQ quality indicators for public reporting or payment - appendix B: public reporting evaluation framework--comparison of recommended evaluation criteria in five existing national frameworks. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005 Dec. B1-4 p. This document is available in PDF from the AHRQ Quality Indicators Web site.
- UCSF-Stanford Evidence-based Practice Center. Davies GM, Geppert J, McClellan M, et al. Refinement of the HCUP quality indicators. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2001 May. (Technical review; no. 4). This document is available in PDF from the AHRQ Quality Indicators Web site.
- HCUPnet, Healthcare Cost and Utilization Project. [internet]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 [Various pagings]. HCUPnet is available from the AHRQ Web site.

NQMC STATUS

This NQMC summary was completed by ECRI on October 1, 2003. The information was verified by the measure developer on October 29, 2003. This summary was updated by ECRI on February 7, 2005. The information was verified by the measure developer on April 25, 2005. This NQMC summary was updated again on February 9, 2006. The information was verified by the measure developer on March 6, 2006.

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